CLIENT REGISTRATION FORM DAAS 101 (Long Form)

NC Department of Health and Human Services • Division of Aging and Adult Services

Section I: Required for all clients

Check the applicable category or categories below and follow corresponding directions.

- HCCBG – congregate nutrition (180), congregate supplemental meals (182), NSIP-only congregate meals (181) **Sections I, II, and VII only**
- HCCBG – general (250) or medical (033) transportation complete **Sections I and VII only**
- Family Caregiver Support Program (services 820, 830, 840, 850); and HCCBG Respite Services [in-home aide respite (236, 237, 238), group respite (309) and institutional respite (210)] **Sections I, VI, and VII (caregiver information) and Sections III, IV, and V (care recipient information)**
- HCCBG - Care management (610), home-delivered meals (020), NSIP-only home-delivered meals (021), home-delivered supplemental meals (022) complete **Sections I, II, IV, V (if appropriate), VI (if appropriate), and VII**
- For all other HCCBG services complete **Sections I, IV, V (if appropriate), VI (if appropriate), and VII**

Service Codes

_____

_____

_____

_____

Region Code_____ **Provider Code**_____

1. Client Status: *Check the appropriate box. More than one box may be appropriate.*

Date

☐ New Registration/Activate (complete all per instructions above) _____

☐ **Waiting for Service:** service codes: ____ ____ ____ (complete Section I - unit based services only) _____

☐ Inactive ☐ applies to client/caregiver OR ☐ applies to care recipient _____

- ☐ adult care home/assisted living
- ☐ alternative living arrangement
- ☐ death
- ☐ hospitalization
- ☐ nursing home placement
- ☐ moved
- ☐ improved function/need eliminated
- ☐ service not needed/wanted
- ☐ illness
- ☐ other (specify) _____

☐ Change (complete Section I, Items 2, 4, 5 and any changed items.) _____

2. Name Last | First | M.I.

4. Last 4 Digits SSN _____ _____ _____ _____

3. Street Address Line 1

5. Date of Birth ____ ____ _____ (MM DD YYYY)

☐ **Special Eligibility** (under age 60)

Mailing Address Line 2

6. Phone # _____ - _____ - _____

☐ No phone

City | State | Zip | County

7. Sex *(check one)*

☐ Female
☐ Male

8. At/Below Poverty Level *(check one)*

☐ Yes
☐ No

9. Marital Status *(check one)*

☐ single (never married)
☐ married
☐ single (divorced/widowed)
☐ refused to answer

10. Household size *(check one)*

☐ lives alone ☐ 2 in home
☐ 3 or more in home
☐ group/shared home
☐ refused to answer

11. Race
Ask: What is your race?

	Check one race which client most closely identifies	*Check all that apply*
a. Black or African-American	☐	☐
b. Asian	☐	☐
c. American Indian or Alaska Native	☐	☐
d. White	☐	☐
e. Native Hawaiian/other Pacific Islander	☐	☐
f. Unknown/refused	☐	☐
g. Other (specify)		

12. Hispanic/Latino *(check one)*
Ask: Are you of Hispanic or Latino origin?

☐ Yes ☐ No

(a person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture of origin, regardless of race)

13. Primary Language Spoken
Ask: What language do you speak in your home?

Language_____

14. Overall Functional Status: ☐ Well ☐ At-risk ☐ High Risk *(If Section IV is required, do not complete.)*

Section II: Required only for clients of HCCBG congregate meals, home-delivered meals, supplemental meals, NSIP-only meals and care management.

15. Nutrition Health Score		Refused to Answer
a. Do you have an illness or condition that made you change the kind and/or amount of food you eat?	☐ Yes ☐ No	☐
b. How many meals do you eat per day?	#	☐
c. How many servings of fruit per day?	#	☐
d. How many servings of vegetables per day?	#	☐
e. How many servings of milk/dairy products per day?	#	☐
f. How many drinks of beer, liquor, or wine do you have every day or almost every day?	#	☐
g. Do you have tooth/mouth problems that make it hard for you to eat?	☐ Yes ☐ No	☐
h. Do you always have enough money or food stamps to buy the food you need?	☐ Yes ☐ No	☐
i. How many meals do you eat alone daily?	#	☐
j. How many prescribed drugs do you take per day?	#	☐
k. How many over-the-counter drugs do you take per day?	#	☐
l. Have you lost or gained 10 or more pounds in the past 6 months without trying?		
Did you gain weight?	☐ Yes ☐ No	☐
Did you lose weight?	☐ Yes ☐ No	☐
m. Are you physically able to:		
Shop for yourself?	☐ Yes ☐ No	☐
Cook for yourself?	☐ Yes ☐ No	☐
Feed yourself?	☐ Yes ☐ No	☐

Section III: Complete on the care recipient (not caregiver) for HCCBG respite (in-home aide respite, group respite and institutional respite) & Family Caregiver Support Program.

CARE RECIPIENT #1 *(For additional service recipients, attach an additional DAAS-101, Section III, IV, and V.)*

16. Name	Last	First	M.I.	**Last 4 Digits SSN** ____ ____ ____ ____
Street Address	Line 1			
Mailing Address	Line 2			**Date of Birth** ____ ____ ____ (MM DD YYYY)
City		State	Zip	

17. Is care recipient a minor child with mental retardation or developmental disability? ☐ Yes ☐ No

18. Does care recipient live in same household as caregiver? ☐ Yes ☐ No

19. Care recipient marital status: *(check one)* ☐ single (never married) ☐ single (divorced/widowed) ☐ married ☐ refused to answer

Section IV: Complete for all clients/recipients except congregate nutrition, transportation or minor relative children for FCSP.

20. Does client (care recipient) have significant memory loss or confusion? ☐ Yes ☐ No

21. Number of IADL (Instrumental Activities of Daily Living)	Client (care recipient) **can** carry out the following tasks **without help.**		*If the answer to items a – h in question #21 or items a – f #22 is "no" then select one of the following:*			
	YES	**NO**	Client (care recipient) **cannot do** and has **someone unpaid** who assists.	Client (care recipient) **cannot do** and has **someone paid** who assists.	Client (care recipient) **cannot do** and has both unpaid & paid assistance.	Client (care recipient) has **no one** who assists.
a. Prepare meals	☐	☐	☐	☐	☐	☐
b. Shop for personal items	☐	☐	☐	☐	☐	☐
c. Manage own medications	☐	☐	☐	☐	☐	☐
d. Manage own money (pay bills)	☐	☐	☐	☐	☐	☐
e. Use telephone	☐	☐	☐	☐	☐	☐
f. Do heavy housework	☐	☐	☐	☐	☐	☐
g. Do light cleaning	☐	☐	☐	☐	☐	☐
h. Transportation ability	☐	☐	☐	☐	☐	☐
Total "no" column = IADL Impairments						

22. Number of ADL (Activities of Daily Living)						
a. Eat	☐	☐	☐	☐	☐	☐
b. Get dressed	☐	☐	☐	☐	☐	☐
c. Bathe self	☐	☐	☐	☐	☐	☐
d. Use the toilet	☐	☐	☐	☐	☐	☐
e. Transfer into/out of bed/chair	☐	☐	☐	☐	☐	☐
f. Ambulate (walk or move about the house without anyone's help)	☐	☐	☐	☐	☐	☐
Total "no" column = ADL Impairments						

23. How many unpaid caregivers involved in care including primary caregiver? Enter #_____

(If answer to this question is "0" skip to Section VII.)

Section V: Complete for HCCBG respite, FCSP, and others responding with "1" or more in # 23.

24. How many hours per day of help, care, or supervision does care recipient need?
a. # of daily hours needed _____ b. If not daily, # of hours per week needed _____

25. How many hours per day of help, care, or supervision does primary caregiver provide?
a. # of daily hours provided _____ b. If not daily, # of hours per week provided _____

26. Primary caregiver's relationship to care recipient: *(check one)*

- ☐ wife
- ☐ husband
- ☐ daughter/ daughter-in-law
- ☐ son/son-in-law
- ☐ sister
- ☐ brother
- ☐ granddaughter/granddaughter-in-law
- ☐ grandson/grandson-in-law
- ☐ niece
- ☐ nephew
- ☐ mother
- ☐ father
- ☐ grandmother
- ☐ grandfather
- ☐ aunt
- ☐ uncle
- ☐ other relative
- ☐ non-relative

Section VI: Complete for all caregivers. Questions 27-30 should be answered only by caregiver.

	1	2	3	4	5
27. Primary caregiver's self-reported health on scale of 1 (poor) to 5 (excellent) *(Choose one.)*					
28. Primary caregiver: How stressful for you is caregiving on a scale from 1 (not at all/very low) to 5 (very high) (*Choose one.)*					

29. Primary caregiver's paid employment status:

- ☐ Full-time
- ☐ Part-time
- ☐ Quit due to caregiving
- ☐ Is not/was not working
- ☐ Retired early due to caregiving
- ☐ Retired/full benefits
- ☐ Lost job/dismissed due to caregiving

30. Is the primary caregiver a long distance caregiver? ☐ Yes ☐ No

Section VII: REQUIRED FOR ALL CLIENTS.

I, the client, understand the information contained on this form will be kept confidential unless disclosure is required by court order or for authorized federal, state or local program reporting and monitoring. I understand that any entitlement I may have to Social Security benefits or other federal or state sponsored benefits shall not be affected by the provision of the aforementioned information. My signature authorizes the providing agency to begin the service(s) requested.

DATE:_____ **CLIENT SIGNATURE:**_____

DATE:_____ **AGENCY EMPLOYEE SIGNATURE:**_____

EMERGENCY CONTACT PERSON

Name:_____

Phone (day):_____-_____-_____ (evening):_____-_____-_____

☐ Refused to provide emergency contact information

Provider Use Only:

Registration Update _____/_____/_____ Staff Initials_____

Registration Update _____/_____/_____ Staff Initials_____

Registration Update _____/_____/_____ Staff Initials_____